The Anscombe Bioethics Centre

Submission to the World Medical Association Public Consultation on a draft revised version of the International Code of Medical Ethics

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The Anscombe Bioethics Centre is the oldest national bioethics centre in the United Kingdom, established in 1977 by the Roman Catholic Archbishops of England and Wales. It was originally known as The Linacre Centre for Healthcare Ethics and was situated in London before moving to Oxford. The Centre engages with the moral questions arising in clinical practice and biomedical research. It brings to bear on those questions principles of natural law, virtue ethics, and the teaching of the Catholic Church, and seeks to develop the implications of that teaching for emerging fields of practice. The Centre engages in scholarly dialogue with academics and practitioners of other traditions. It contributes to public policy debates as well as to debates and consultations within the Church.

We are grateful to have the opportunity to respond to the World Medical Association consultation on the draft revision on the International Code of Medical Ethics.

A key issue: conscientious objection

For the first time this draft Code introduces the idea of "conscientious objection":

Paragraph 27 reads:

> "Physicians have an ethical obligation to minimise disruption to patient care. Conscientious objection must only be considered if the individual patient is not discriminated against or disadvantaged, the patient's health is not endangered, and undelayed continuity of care is ensured through effective and timely referral to another qualified physician.*
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> * This paragraph will be debated in greater detail at the WMA's dedicated conference on the subject of conscientious objection in 2021 or 2022. However, comments on this paragraph are also welcome at this time."

Unfortunately, this is deeply problematic as a statement of the rights of conscience in medicine. In the first place it utterly fails to establish the duty of doctors to object to practices and procedures that are unconscionable because harmful, discriminatory, unjust or unethical. The right to conscientious objection is based on the duty to be conscientious which is fundamental to medical ethics.

In the second place, "conscientious objection" is presented as conflicting with "patient care". This overlooks the fact that there can be no adequate patient care without conscientious healthcare professionals. To assume that disruption or inconvenience caused by conscientious objection undermines patient care begs the question. If the practice or procedure is ethically objectionable then hastening the delivery of the procedure does not enhance patient care; it harms it.

Even leaving aside whether the doctor is correct in thinking that the procedure is incompatible with good patient care, the fact that the doctor believes the procedure is unethical is reason not to require the doctor to facilitate it. This is easier to see from examples. A doctor might, for example, conscientiously object to infant male circumcision, to conversion therapy (in jurisdictions where this is legal), to skin whitening or to disabling surgery such as elective amputation. It would be contrary to that individual doctor's judgement of good patient care to arrange "effective and timely referral" to a practitioner who would provide the service. Again, if a doctor objects in conscience to participation in torture or capital punishment or to force feeding of a prisoner who is on hunger strike, it would be unprincipled for them to find someone with fewer scruples to do the deed for them. To require a conscientious objector to facilitate delivery of the procedure to which they object is a direct attack on person's conscience and moral integrity, and thus a serious harm to them. It would be much better to say nothing about conscientious objection than to undermine it by imposing a requirement for "effective and timely referral".

A related issue: assisted suicide and euthanasia

The consultation document states that "The mandate of this workgroup is to update the International Code of Medical Ethics to be more compatible with the revised Declaration of Geneva and the full spectrum of WMA policy". However, the draft Code neglects an important WMA policy directly relevant to medical ethics and linked to the webpage for the current International Code of Medical Ethics. This is the WMA policy on euthanasia or assisted suicide.

In that policy statement, the WMA expresses its firm opposition to euthanasia and assisted suicide and further states that "No physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referral decisions to this end". This policy statement is an expression of the right of conscientious objection and overtly includes a right not to have to make effective referrals for these procedures.

The WMA policy is directly relevant to the situation of physicians in jurisdictions where euthanasia or assisted suicide is legal. The policy provides a basis to challenge the legal and medical authorities in Canada in their efforts to impose on all physicians a requirement to refer for "medical assistance in dying". It also provides an argument against those in California who are seeking to strip away the conscience protections in the End of Life Option Act.

The draft revision of the International Code of Medical Ethics not only fails to make explicit reference to the right to object in conscience to participation in euthanasia and assisted suicide. By imposing a requirement for "effective and timely referral" the draft revision is *incompatible* with WMA policy which states that there must be no obligation "to make referral decisions to this end". The draft revision of the Code contradicts agreed WMA policy and exposes doctors in countries with euthanasia or assisted suicide to increased pressure to facilitate these practices.

What can be done

The draft revision is incompatible with current WMA policy on euthanasia and assisted suicide. The revision of the Code must not require physicians to refer patients for unconscionable procedures. The present draft revision would coerce physicians to act against their consciences or would drive conscientious professionals out of healthcare. This in turn would harm patients, who need to be cared for by those who take their ethical responsibilities seriously.

It is better not to include an item on conscientious objection than to impose a requirement that undermines rights of conscience. Better still is to include a robust right of conscientious objection - citing as an example a right not to participate in euthanasia and assisted suicide - and to make clear that this right includes a right not to refer for the procedure concerned. Below is a draft statement on conscientious objection from the Anscombe Bioethics Centre, included in case it may be helpful. The key point of this submission is that the WMA should remove from the revision the deeply unethical requirement that physicians refer patients for procedures they see as unconscionable.

A statement on conscientious of objection for the WMA working group to consider:

The duty of a physician to practise with conscience includes the duty not to act against conscience. Physicians have a duty and hence a right to object to undertaking or facilitating procedures that they regard as harmful, discriminatory, unjust or otherwise unethical. The right of conscientious objection, for example, the right to refuse to participate in euthanasia or assisted suicide, includes the right not to make referral decisions to this end.

A principled conscientious objection is always to a procedure and not to a person. Physicians must not refuse to treat a particular patient or group of patients because of beliefs about them unconnected with the medical appropriateness of the procedure. In particular, physicians must not refuse to treat criminals or enemy combatants or refuse to treat the health consequences of harmful lifestyle choices.

A physician must ensure that conscientious objection is exercised in a way that takes full account of their duty of care for the life and health of the patient and does not unnecessarily and deliberately encroach upon the patient's treatment plans. Physicians should make their conscientious objections known to colleagues and employers. If a

patient's request is declined on the basis of a conscientious objection, the physician should where appropriate explain the reasons for the decision and explain other options that are available to the patient, including the option to seek a transfer of care to some other healthcare professional. Mentioning this factual possibility does not imply an intention that the requested procedure be sought or obtained elsewhere.

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